MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

4050

Reg. Dist. No. 03982

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Route # 3

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Berlin
d. STREET ADDRESS: Route # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Clara — Middle — Last Briddell

4. DATE OF DEATH: Month 3 — Day 19 — Year 1960

5. SEX: Fem.

6. COLOR OR RACE: AA

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-15-1861

9. AGE (In years last birthday): 98 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Bethards

14. MOTHER'S MAIDEN NAME: Hester Hammond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: No

INFORMANT — Address: Joseph C. Briddell - Rt # 3 - Berlin, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease
DUE TO (b): Senility
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

INTERVAL BETWEEN ONSET AND DEATH: Several years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-23, 1959, to 3/12, 1960, that I last saw the deceased alive on 3/12, 1960, and that death occurred at 5 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ivory U. Sully Jr. M.D. — ADDRESS (Street, city or town, state): Berlin, Md — DATE SIGNED: 3/24/60

PHYSICIAN'S NAME (Type): Ivory U. Sully, Jr., MD — Berlin, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-26-60

22c. NAME OF CEMETERY OR CREMATORY: New Bethel Cem

22d. LOCATION (City, town, or county) (State): Berlin, Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Thornton B Jolley, Salisbury Md.

24a. REC'D BY REGISTRAR DATE: APR 4 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4051 **CERTIFICATE OF DEATH** 03983

Reg. Dist. No.

1. PLACE OF DEATH — a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN MD RTH 2
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Md — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Berlin, Md (RFD #2)
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First MABLE — Middle W. — Last CATHELL
4. DATE OF DEATH: Month March — Day 16 — Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/27/08
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edgar Evans
14. MOTHER'S MAIDEN NAME: Mattie Hudson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Harry Cathell Berlin Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute bronchial asthmatic attack	1/2 hr
241 X — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Chronic Bronchial Asthma	2 yrs
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-14, 1958, to 3-8, 1960, that I last saw the deceased alive on 3-8, 1960, and that death occurred at 6:00 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ivory V. Sully Jr M.D. — ADDRESS (Street, city or town, state): Berlin Md — DATE SIGNED: 3/16/60

PHYSICIAN'S NAME (Type): Ivory V. Sully, Jr MD — Berlin, Md

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3/20/60	St Georges Cem.	Clarksville Delaware

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Watson + Gray Frankford, Del.
24a. REC'D BY REGISTRAR DATE: MAR 22 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4043 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03984

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b: 66 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BERLIN
d. STREET ADDRESS: 1 WILLIAMS ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

3. NAME OF DECEASED (Type or print): First VAUGHN Middle EVERETT Last CROPPER

4. DATE OF DEATH: Month MARCH Day 5 Year 1960

5. SEX: M

6. COLOR OR RACE: WH

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 15 1894

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED MERCHANT

10b. KIND OF BUSINESS OR INDUSTRY: OWN STORE

11. BIRTHPLACE (State or foreign country): BERLIN MD (RFD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH CROPPER

14. MOTHER'S MAIDEN NAME: ELIZABETH TURNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: MRS. V. EVERETT CROPPER BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Thrombosis with — INTERVAL BETWEEN ONSET AND DEATH: 10 Min

420.1

DUE TO (b): Acute Pulmonanry Edema — Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Coronery Artery Disease — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Herman A Robbins M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3/6/60

EXAMINER'S NAME (Type): Herman A Robbins M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3/8/60

22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

22d. LOCATION (City, town, or county): BERLIN (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage

ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: MAR 10 '60

24b. REGISTRAR'S SIGNATURE: Cullen L. Travers

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4048

CERTIFICATE OF DEATH

03985 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
c. LENGTH OF STAY IN 1b 3 Mo 23 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Snow Hill
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Pecora Middle Mae Last Jackson

4. DATE OF DEATH Month March Day 5 Year 1960

5. SEX Female

6. COLOR OR RACE Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Nov. 12 1959

9. AGE (In years last birthday) — yrs. IF UNDER 1 YEAR Months 3 Days 23 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Snow Hill Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Owen Jackson

14. MOTHER'S MAIDEN NAME Helen Beckett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

INFORMANT Mrs Helen Jackson Address Snow Hill Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH 2 DAYS
DUE TO
491X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MARCH 4, 1960, to MARCH 5, 1960, that I last saw the deceased alive on March 5, 1960, and that death occurred at 4 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Robert C. LaMar M.D. ADDRESS (Street, city or town, state) 104 Bay Street DATE SIGNED

PHYSICIAN'S NAME (Type) Robert C. LaMar, M. D. Snow Hill, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF March 6 '60

22c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery

22d. LOCATION (City, town, or county) Snow Hill (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Ellery E. Burris ADDRESS Snow Hill Md

24a. REC'D BY REGISTRAR DATE MAR 8 '60

24b. REGISTRAR'S SIGNATURE Ouida L. Evans

40VV246XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4046 — 03986 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pocomoke City
d. STREET ADDRESS: 1 R.F.D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary — Middle — Last Jones
4. DATE OF DEATH: Month Mar. — Day 5 — Year 19 60

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 8, 1917
9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farm Work
11. BIRTHPLACE (State or foreign country): Beaufort Co.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: Martha JONES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Perlie Jones — Address: Pocomoke City, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhage (Heart) — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Due to Stab wound
DUE TO (c): " " Homicide
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 982X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Drinking Alcoholic drinks
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Stabbed by another person following a party
20c. TIME OF INJURY: Hour 3:30 p.m. — Month, Day, Year: Mch 4 1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Pocomoke City (County) Worcester (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

ACTUAL SIGNATURE: N. E. Sartorius M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): N.E Sartorius
DATE SIGNED: 3/4/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/18/60
22c. NAME OF CEMETERY OR CREMATORY: Beaufort
22d. LOCATION (City, town, or county) (State): Beaufort, N.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton — ADDRESS: New Church, Va.
24a. REC'D BY REGISTRAR DATE: MAR 18 '60
24b. REGISTRAR'S SIGNATURE: Caitlin S. Fraser

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Mc Cabe

4044

03987

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY [illegible] MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
c. LENGTH OF STAY IN 1b [illegible]
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) [illegible]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE [illegible] b. COUNTY [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
d. STREET ADDRESS R.F.D. [illegible]
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First [illegible] Middle H. Mc [illegible] Last [illegible]
4. DATE OF DEATH: Month March Day 6 Year 1960
5. SEX: M
6. COLOR OR RACE: [illegible]
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: [illegible] 14, 1884
9. AGE (In years last birthday) 75 yrs.
IF UNDER 1 YEAR: Months [illegible] Days [illegible]
IF UNDER 24 HRS.: Hours [illegible] Min. [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible]
10b. KIND OF BUSINESS OR INDUSTRY Own farm
11. BIRTHPLACE (State or foreign country) [illegible] (Md.)
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joshua McCabe
14. MOTHER'S MAIDEN NAME Margaret [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [illegible] (If yes, give war or dates of service) [illegible]
16. SOCIAL SECURITY NO. [illegible]
17. INFORMANT Address R. Linwood McCabe [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Thrombosis	?
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Coronary Artery Disease	1 yr
DUE TO	Coronary Sclerosis	3-4 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour [illegible] a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Herman A. Robbins M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 8 Mar 60
EXAMINER'S NAME (Type) Herman A Robbins M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 5/10/60
22c. NAME OF CEMETERY OR CREMATORY EVERGREEN
22d. LOCATION (City, town, or county) BERLIN (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE Emma C. Burbage ADDRESS Berlin Md
24a. REC'D BY REGISTRAR DATE MAR 15 '60
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. [illegible] delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the [illegible] director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03968

4052

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stockton
c. LENGTH OF STAY IN 1b: 1 yr

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Snow Hill
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

3. NAME OF DECEASED (Type or print): First: Margaret Middle: A. Last: Melson

4. DATE OF DEATH: Month: March Day: 13 Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 10-1869

9. AGE (In years last birthday): 90 yrs 10 mos 3 ds

IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Snow Hill Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frederick Haubert

14. MOTHER'S MAIDEN NAME: Mary Briddell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Byron Dill, Address: Snow Hill, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 12 Hrs

DUE TO (b): Myocardial Insufficiency — 1 yr

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Lobar Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1948 19__ to 3-13-60, that (I) (~~saw~~) last saw the deceased alive on 3-13-60, and that death occurred at 10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert C. LaMar M.D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: March 15, 1960

22c. PHYSICIAN'S NAME (Type): Robert C. LaMar, M. D.

22d. ADDRESS: 104 Bay Street, Snow Hill, Md

23a. BURIAL CREMATION REMOVAL (Specify) 23b. DATE THEREOF: Burial March 16/60

23c. NAME OF CEMETERY OR CREMATORY: Pitts Methodist

23d. LOCATION (City, town, or county) (State): Snow Hill Md

24. FUNERAL DIRECTOR'S SIGNATURE: Elbert E. Timms ADDRESS: Snow Hill Md

25a. REC'D BY REGISTRAR DATE: MAR 16 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Timms

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

4047 — 03983 — Reg. Dist. No.

1. PLACE OF DEATH
a COUNTY: Worcester — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 14 Greenway Avenue

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: Maryland — b COUNTY: Worcester
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
d. STREET ADDRESS: 1509 Linden Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First BERTIE — Middle H. — Last MERRILL

4. DATE OF DEATH: Month March — Day 21 — Year 1960

5 SEX: Female
6 COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 22,1891
9 AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Virginia
12 CITIZEN OF WHAT COUNTRY: USA

13 FATHER'S NAME: Edward Thomas Hope
14 MOTHER'S MAIDEN NAME: Sudie B. Bundick

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: W. H. Merrill Jr., Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Few Minutes

420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Generalized atherosclerosis — Years
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arthritis, Chronic.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 4, 1959, to Mar. 21, 1960, that I last saw the deceased alive on Mar 21, 1960, and that death occurred at ____M, from the causes and on the date stated above

ACTUAL SIGNATURE: Charles W Trader M.D.
ADDRESS (Street, city or town, state): 302 Market St. Pocomoke City, Md.
DATE SIGNED: 3-22-60
PHYSICIAN'S NAME (Type): Charles W. Trader, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-24-60
22c NAME OF CEMETERY OR CREMATORY: Bethany Methodist
22d. LOCATION (City, town, or county) (State): Pocomoke City, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Robert H. Watson
ADDRESS: Pocomoke City, Md
24a. REC'D BY REGISTRAR DATE: MAR 28 '60
24b REGISTRAR'S SIGNATURE: Clifton L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03950

4049

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
c. LENGTH OF STAY IN 1b 46 yrs
d. NAME OF HOSPITAL (If not in hospital give street address OR INSTITUTION 204 Bell Street

2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE Md b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Snow Hill
d. STREET ADDRESS 204 Bell
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First William Middle L Last Mills
4. DATE OF DEATH Month March Day 14 Year 1960

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH March 21-1911
9. AGE (In years last birthday) 48 Yrs 23 Days
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker
10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill
11. BIRTHPLACE (State or foreign country) Snow Hill, Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Ernest L. Mills
14. MOTHER'S MAIDEN NAME Annie Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service Yes World War II
16. SOCIAL SECURITY NO. 216-07-4271
17. INFORMANT Address Mrs Margaret L. Mills, Snow Hill, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Pulmonary Edema	1 day
241X DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO	Myocardial Insufficiency	6 mos.
(c)	Chronic Bronchial Asthma	1½ yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchiectasis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1956 19___ to 3-14-60 19___, that (I) ~~(we)~~ last saw the deceased alive on 3-12-60, and that death occurred at 2:00 A M, from the causes and on the date stated above

22a. SIGNATURE Ruth LaMar M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED March 15, 1960
22c. PHYSICIAN'S NAME (Type) Robert C. LaMar, M. D.
22d. ADDRESS 104 Bay Street, Snow Hill, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF March 17/60
23c. NAME OF CEMETERY OR CREMATORY Whatcoat Cemetery
23d. LOCATION (City, town, or county) (State) Snow Hill Md

24. FUNERAL DIRECTOR'S SIGNATURE Lilley & Timmis
ADDRESS Snow Hill, Md
25a. REC'D BY REGISTRAR DATE MAR 16 '60
25b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4053 **CERTIFICATE OF DEATH**

Reg. Dist. No. 03951

1. PLACE OF DEATH
a. COUNTY Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Newark
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First George Middle Edward Last Pointer
4. DATE OF DEATH Month Mar. Day 6 Year 19 60

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH June 11, 18 97
9. AGE (In years last birthday) 62 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY Own Farm
11. BIRTHPLACE (State or foreign country) Berlin Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME George E. Pointer
14. MOTHER'S MAIDEN NAME Margaret Quillen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO 213-12-8297
INFORMANT Mrs. G. E. Pointer Address Newark Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cardiac Dilation — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Chr. Brights — 2 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 24 —, 1960, to March 6, 1960 that I last saw the deceased alive on March 5 —, 1960, and that death occurred at 7:30 AM, from the causes and on the date stated above.
ACTUAL SIGNATURE Chas. R. Law M.D
ADDRESS (Street, city or town, state) Berlin Md
DATE SIGNED March 8-1960
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/7/60
22c. NAME OF CEMETERY OR CREMATORY Evergreen
22d. LOCATION (City, town, or county) Berlin (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Horace A. Purnell
ADDRESS Berlin Md
24a. REC'D BY REGISTRAR DATE MAR 10 '60
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4054

CERTIFICATE OF DEATH

Reg. Dist. No. 03992

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Newark
c. LENGTH OF STAY IN 1b: life time
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Route #1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Newark
d. STREET ADDRESS: Route #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle — Last Selby

4. DATE OF DEATH: Month 3 — Day 24 — Year 19 60

5. SEX: M

6. COLOR OR RACE: AA

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-14-1865

9. AGE (In years last birthday): 94 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Selby

14. MOTHER'S MAIDEN NAME: Talbothy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

INFORMANT — Address: Mrs. Margie Johnson, Rt #1, Newark, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocarditis — INTERVAL BETWEEN ONSET AND DEATH

431 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-24, 1960 to 3-24 60, that I last saw the deceased alive on 3-24-60, 19____, and that death occurred at 7.00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clifford E Schott M.D. — ADDRESS (Street, city or town, state): 314 N. Main Berlin Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Clifford E. Schott. M.D. — 314 N. Main Street, Berlin, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-31-60

22c. NAME OF CEMETERY OR CREMATORY: Cedar Chapel Cem.

22d. LOCATION (City, town, or county) (State): Newark, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Thornton B. Jolley, Salisbury, Md

24a. REC'D BY REGISTRAR DATE APR 4 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4045 — Reg. Dist. No. 03993

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Berlin
d. STREET ADDRESS: 1 Franklin Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Clinton — Middle Boston — Last Taylor
4. DATE OF DEATH: Month Mar. — Day 19 — Year 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 18, 1919
9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10b. KIND OF BUSINESS OR INDUSTRY: Own Store
11. BIRTHPLACE (State or foreign country): Newark Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Taylor
14. MOTHER'S MAIDEN NAME: Mary Bostin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War II
16. SOCIAL SECURITY NO.: 220-01-8694
17. INFORMANT — Address: Mrs. C.B. Taylor, Berlin Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Perforating G.S.W. left side of chest — INTERVAL BETWEEN ONSET AND DEATH: 15 Min
DUE TO
(b): through heart,
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Melancholy

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Self Inflicked with 25 cal automatic pistol
20c. TIME OF INJURY: Hour 11 a. m. p. m. — Month, Day, Year: Mar 19 1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Berlin Worcestor Co

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Herman A Robbins M.D. — M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED
EXAMINER'S NAME (Type): Herman A Robbins M.D. — March 21, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/22/60
22c. NAME OF CEMETERY OR CREMATORY: Evergreen
22d. LOCATION (City, town, or county) (State): Berlin Md

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage
ADDRESS: Berlin Md.
24a. REC'D BY REGISTRAR DATE: MAR 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. ... delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to ... funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55